Employee Benefits Guide

2024

ADDISON HUMAN RESOURCES

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Working together is what makes Town of Addison a success, and this teamwork extends to your benefits program. The employee benefits package offered by the Town of Addison is an important part of your total compensation as an employee. The coverage you elect, as an employee, will help meet the needs of you and your family. This guide offers details on your benefits for the 2024 plan year.

Town of Addison offers a comprehensive, cost-effective, and competitive benefits package for you and your family, but it works when you take control and make decisions about your benefits. Please review the following pages for your benefit options and your 2024 employee contributions.

See page 37 for important information concerning Medicare Part D coverage.

In this Guide, we use the term company to refer to Town of Addison. This Guide is intended to describe the eligibility requirements, enrollment procedures, and coverage effective dates for the benefits offered by the company. It is not a legal plan document and does not imply a guarantee of employment or a continuation of benefits. While this Guide is a tool to answer most of your questions, full details of the plans are contained in the Summary Plan Descriptions (SPDs), which govern each plan's operation. Whenever an interpretation of a plan benefit is necessary, the actual plan documents will be used.

Welcome

Town of Addison offers comprehensive benefits options for you and your family, including medical, dental, vision, life and disability, retirement, and additional benefits coverage. We are committed to excellence in our work and in our offerings for 2024.

This guide includes:

- An overview of your 2024 benefits options
- Explanations of each offering to help you make the best decisions for you and your family
- Contact information for all benefits vendors
- Costs associated with your benefits

What's changing this year?

- Per IRS mandate, the in-network deductible and out-of-pocket maximum for the HDHP will increase from $3,000/$6,000 to $3,200/$6,400

What's not changing this year?

- All current benefit vendors remain the same (this means if your doctor was in-network last year, they will remain in-network for the new 2024 plan year)
- Even though healthcare costs grow steadily each year across the United States, Town of Addison cares about your overall health and has worked hard to provide NO increase to employee premium contributions for 2024

Any questions?

We're here to help. Contact your Town of Addison Human Resources Team below.

Town of Addison Human Resources

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Full-Time Employee Premiums at a Glance

HDHP (HSA) PLAN

MEDICAL INSURANCE

	YOU PAY BI-WEEKLY	TOWN OF ADDISON PAYS
EMPLOYEE ONLY	$5.00	$278.48
EMPLOYEE + SPOUSE	$202.43	$562.16
EMPLOYEE + CHILD(REN)	$124.38	$456.24
EMPLOYEE + FAMILY	$282.89	$671.40

PPO PLAN

MEDICAL INSURANCE

	YOU PAY BI-WEEKLY	TOWN OF ADDISON PAYS
EMPLOYEE ONLY	$7.50	$329.98
EMPLOYEE + SPOUSE	$246.14	$664.09
EMPLOYEE + CHILD(REN)	$152.02	$539.19
EMPLOYEE + FAMILY	$343.19	$792.87

DENTAL INSURANCE

	YOU PAY BI-WEEKLY	TOWN OF ADDISON PAYS
EMPLOYEE ONLY	$0.00	$15.94
EMPLOYEE + SPOUSE	$7.50	$23.45
EMPLOYEE + CHILD(REN)	$9.13	$25.07
EMPLOYEE + FAMILY	$19.63	$35.58

VISION INSURANCE

	YOU PAY BI-WEEKLY	TOWN OF ADDISON PAYS
EMPLOYEE ONLY	$3.60	–
EMPLOYEE + SPOUSE	$6.84	–
EMPLOYEE + CHILD(REN)	$7.20	–
EMPLOYEE + FAMILY	$10.59	–

Eligibility and Enrollment

Town of Addison's benefits are designed to support your unique needs. Please note the Town will request proof of relationship.

Eligibility

If you are a full-time employee of Town of Addison who is regularly scheduled to work 30 or more hours per week, you are eligible to enroll in the Town of Addison's benefit program during your first 30 days of continuous employment. Some part-time employees may be eligible for benefits. Contact Human Resources for more information on eligibility.

Dependent Eligibility - Medical, Dental & Vision

Dependents eligible for coverage include:

- Your legal spouse (or common-law spouse where recognized).
- Your Domestic Partner (Human Resources may request additional documents as proof of eligibility).
- Children up to age 26 (includes birth children, stepchildren, legally adopted children, children placed for adoption, foster children, and children for whom you or your spouse have legal guardianship).
  - For Dental: children up to age 25
- Dependent children 26 or more years old, unmarried, and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability which arose while the child was covered as a dependent under this plan (periodic certification may be required).

Important: Any employee who adds a dependent to their medical, dental, vision and/or life insurance coverage will be required to provide documentation which demonstrates that the individual meets the Town's eligibility criteria for the benefit being selected.

Getting Ready To Enroll

Open Enrollment is your annual chance to consider your benefits carefully. After your enrollment period ends, you cannot change your 2024 benefit choices during the year unless you have a qualifying life event, such as marriage or the birth/adoption of a child.

Items You May Need:

- Social security numbers and birth dates for yourself and your eligible family members. Please see criteria below for adding a dependent.
  - For adding a child – a copy of the child's birth certificate/ verification of birth facts is needed
  - For adding a spouse – a copy of the marriage certificate is needed
- Information about other benefit coverage or insurance you or a family member may have.
- Beneficiary designation information, so you can properly identify your beneficiaries for your life insurance coverage.
- Out-of-pocket expense records for your medical, dental, vision, and dependent care so you can plan your Flexible Spending Account contribution amounts.

Passive Enrollment

This year we are conducting a **"Passive Enrollment."** This means your benefits elections will automatically roll over to the next plan year. You do not need to take any action unless you:

- Would like to change or decline your current benefits, including who from your family is covered.
- Would like to purchase additional voluntary life insurance for yourself, spouse, and/or child.
- If you are declining health insurance, you must complete a declination form and submit it to the Human Resources department. Note: This is an annual requirement.

Any new elections you make or those that roll over will remain in place until the following enrollment period unless you experience a qualifying life event.

Be Alert! Check your first paycheck in January to confirm that your payroll deductions are correct. Report any payroll discrepancies immediately to the Human Resources Department.

Know Your Benefit Enrollment Opportunities

There are certain times throughout the year when you may enroll in health and supplemental insurance benefits or change your coverage. Please see below.

Open Enrollment: October 25, 2023 to November 8, 2023

This is the opportunity to change your health plans, change from family to individual coverage, enroll if you had previously deferred coverage, cancel coverage for yourself or an adult dependent child and more.

Open enrollment is available to employees, retirees, currently insured COBRA continuants, surviving spouses and dependents. Changes become effective January 1, 2024.

If you are not changing medical, dental, and vision coverage, you do not need to do anything. If you participate in one or both of the Flexible Spending Accounts, you MUST enroll each year if you want to participate in these accounts. Your elections for these accounts do not automatically carry over.

What are Qualifying Life Events?

While you can update your benefits when you start a new job or during Open Enrollment, changes in your life called Qualifying Life Events (QLEs) determined by the IRS can allow you to enroll in health insurance or make changes outside of these times.

When a Qualifying Life Event occurs, you have 30 days to request changes to your coverage. Your change in coverage must be consistent with your change in status. If you have a qualifying event, you must notify the Human Resources Department as soon as possible and before the 30 days have passed. If you wait longer than 30 days, you will not be allowed to make any coverage changes until the next annual enrollment period – per IRS regulations.

New Employees

If you are electing health insurance coverage, you must enroll within 30 days of your date of hire (in an eligible position). Coverage will be effective on your hire date, or on the date you are eligible for coverage.

Common qualifying events include:

- A change in the number of dependents (through birth or adoption or if a child is no longer an eligible dependent)
- A change in a spouse's employment status (resulting in a loss or gain of coverage)
- A change in your legal marital status (marriage, divorce, or legal separation)
- A change in employment status from full time to part time, or part time to full time, resulting in a gain or loss of eligibility
- Eligibility for coverage through the Marketplace
- Changes in address or location that may affect coverage
- Entitlement to Medicare or Medicaid

Some lesser-known qualifying events are:

- Turning 26 and losing coverage through a parent's plan
- Death in the family (leading to change in dependents or loss of coverage)
- Changes that make you no longer eligible for Medicaid or the Children's Health Insurance Program (CHIP)
- IMPORTANT NOTE: Newborns are NOT automatically added to your medical coverage under Town of Addison benefit plans. You must notify the Human Resources Department within 30 days of birth to add the newborn. Also, please be sure to provide a Social Security number once it is received.

Reach out to Town of Addison's Human Resources with questions regarding specific life events and your ability to request changes. Don't miss out on a chance to update your benefits!

Mental Health

You visit your doctor when you're feeling sick, and you exercise and eat healthy to keep your body strong. But your mental health is just as important. What do you do to stay healthy mentally? Do you know where you can go when you need help? Whether you need assistance with work-life balance or anxiety, there are resources available to help you out.

Mental Health and Your Medical Plan

When your covered EAP services run out, the medical plan covers behavioral and mental health services at 100% after deductible on the HDHP plan or at a $20 copay on the PPO plan per visit. Coverage includes virtual therapy from BCBS. Via video or telephone, you can receive confidential 1-on-1 counseling from the privacy and convenience of your home. Your licensed virtual therapist may provide a diagnosis, treatment, and medication if needed. You can see the same therapist with each appointment and establish an ongoing relationship. See plan documents for specifics on coverage for inpatient and outpatient services.

An important aspect of your overall wellbeing is emotional wellness – the ability to successfully adapt to changes and challenges as they arrive and handle life's stresses. These five actions have been shown to improve emotional wellness.

The Big Five of Emotional Wellness

1

Practice mindfulness.

Practice deep breathing, enjoy a stroll, and stay present in each moment.

2

Strengthen social connections.

Reach out to a friend or family member daily — even if it's just a video call or text.

3

Get quality sleep.

Keep a consistent sleep schedule and limit electronic use before bed.

4

Improve your outlook.

Treat people with kindness, including yourself.

5

Deal with your stress.

Think positively, exercise regularly, and set priorities.

Other Mental Health Resources

No matter your problem, whether you're a manager or entry-level employee, don't be afraid to ask for help. There are resources available 24/7.

988 Suicide & Crisis Lifeline

Dial 988 to be connected with 24/7/365 emotional support.

Free, confidential crisis counseling, including appropriate follow-up services, is available no matter where you live in the United States.

Crisis Text Line

Text "HELLO" to 741741

Send a text 24/7 to the Crisis Text Line to speak with a crisis counselor who can provide support and information. Standard text messaging rates may apply.

War Vet Call Center

Veterans and their families call 877-WAR-VETS (877-927-8387) to talk about their military experience and/or readjustment to civilian life.

Call 911 if you or someone you know is in immediate danger or go to the nearest emergency room.

Note

According to the American Psychological Association, 77% of workers are satisfied with the support for mental health and well-being they receive from their employers in 2023.

Medical Benefits

Town of Addison offers a PPO medical plan and a High Deductible Health Plan medical plan, both administered by Blue Cross Blue Shield of Texas. Both plans cover a wide variety of medical services, including office visits, prescription drugs, and inpatient and outpatient care and use the BlueChoice Network.

2024 Plan Year Medical Contributions: Effective January 1 to December 31, 2024

Premium contributions for medical are deducted from your paycheck on a pre-tax basis. Your level of coverage determines your bi-weekly contributions.

FULL-TIME

BI-WEEKLY CONTRIBUTIONS	PPO EMPLOYEE COST	PPO ADDISON COST	HDHP EMPLOYEE COST	HDHP ADDISON COST
EMPLOYEE ONLY	$7.50	$329.98	$5.00	$278.48
EMPLOYEE + SPOUSE	$246.14	$664.09	$202.43	$562.16
EMPLOYEE + CHILD(REN)	$152.02	$539.19	$124.38	$456.24
EMPLOYEE + FAMILY	$343.19	$792.87	$282.89	$671.40

PART-TIME .7

BI-WEEKLY CONTRIBUTIONS	PPO EMPLOYEE COST	PPO ADDISON COST	HDHP EMPLOYEE COST	HDHP ADDISON COST
EMPLOYEE ONLY	$87.02	$250.46	$73.16	$210.32
EMPLOYEE + SPOUSE	$407.00	$503.23	$336.33	$428.26
EMPLOYEE + CHILD(REN)	$284.65	$406.56	$234.85	$345.77
EMPLOYEE + FAMILY	$533.17	$602.89	$440.92	$513.38

PART-TIME .5

BI-WEEKLY CONTRIBUTIONS	PPO EMPLOYEE COST	PPO ADDISON COST	HDHP EMPLOYEE COST	HDHP ADDISON COST
EMPLOYEE ONLY	$145.03	$192.45	$121.93	$161.55
EMPLOYEE + SPOUSE	$514.24	$395.99	$425.58	$339.01
EMPLOYEE + CHILD(REN)	$373.06	$318.15	$308.50	$272.12
EMPLOYEE + FAMILY	$659.82	$476.24	$546.27	$408.03

How to Find a Provider

Visit www.bcbstx.com or call Customer Care at 800-521-2227 for a list of BCBSTX network providers.

Did You Know?

Preventive care offered by an in-network physician, such as an annual physical, is covered by the plans at 100%.

PPO Plan

PPO medical plans allow you the freedom to choose either an in-network or out-of-network provider each time you need medical care.

Care received from network providers is paid at a higher benefit level, and you usually have no claims to file. If you choose to receive care from a non-network provider, medical benefits are lower – and you may have to file a claim to receive reimbursement for covered expenses.

This chart summarizes the 2024 medical coverage provided under the PPO plan. All covered services are subject to medical necessity as determined by the plan. Please note that all out-of-network services are subject to Reasonable and Customary (R&C) limitations. The PPO plan has no lifetime maximum.

	PPO	
	IN-NETWORK	OUT-OF-NETWORK
CALENDAR YEAR DEDUCTIBLE		
INDIVIDUAL	$500	$1,000
FAMILY	$1,000	$2,000
COINSURANCE (YOU PAY)	20%*	40%*
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (MAXIMUM INCLUDES DEDUCTIBLE)		
INDIVIDUAL	$2,000	$3,000
FAMILY	$4,000	$6,000
COPAYS/COINSURANCE		
PREVENTIVE CARE (Routine Physicals, Well Baby Care, Vision & Hearing Exams)	100% covered	40%*
PRIMARY CARE	$20 copay/visit	40%*
SPECIALIST SERVICES	$20 copay/visit	40%*
VIRTUAL VISIT	$20 copay/visit	40%*
IN/OUTPATIENT HOSPITAL	20%*	40%*
MENTAL HEALTH - INPATIENT	20%*	40%*
MENTAL HEALTH - OUTPATIENT	$20 copay/visit	40%*
INPATIENT SUBSTANCE ABUSE	20%*	40%*
OUTPATIENT SUBSTANCE ABUSE	$20 copay/visit	40%*
URGENT CARE	20% after $35 copay	40%*
EMERGENCY CARE (Facility Charges and Ambulance Charges)	20% after $50 copay 20% after deductible	
EXTENDED CARE (Home Health Care, Skilled Nursing Facility, Hospice Care)	20%* (See HR for maximums)	40%* (See HR for maximums)

*After deductible

The individual deductible amount must be met by each member enrolled under your medical coverage. If you have several covered dependents, all charges used to apply toward a "per individual" deductible amount will also be applied toward the "per family" deductible amount. When the family deductible amount is reached, no further individual deductibles will have to be met for the remainder of that plan year. No member may contribute more than the individual deductible amount to the "per family" deductible amount. The same typically applies for the out-of-pocket maximum.

Healthcare Cost Transparency

There are so many different providers and varying costs for healthcare services — how do you choose? Online services called healthcare cost transparency tools can help. These tools allow you to compare costs for services, from prescriptions to major surgeries, to make your choices simpler. Visit www.bcbstx.com to learn more.


ADDISON


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PUBLIC WORKS AND ENGINEERING SERVICES

High Deductible Health Plan (HDHP)

In the HDHP plan, you also choose to receive medical care from in-network or out-of-network providers, but you pay less out of your paycheck for your premiums and more out-of-pocket for expenses. The HDHP has higher annual deductibles and no office visit copays. Prescription drugs are also subject to the plan's deductibles. Once you meet the in-network or out-of-network deductible, you and the plan begin sharing expenses. The HDHP has a $3,200 individual deductible and a $6,400 family deductible.

Once your share of in-network costs reaches the deductible, you will automatically hit the out-of-pocket maximum of $3,200 (individual), or $6,400 (family). At that time, the plan will then pay 100% of your eligible expenses for the rest of the calendar year.

This chart summarizes the 2024 medical coverage provided under the HDHP. All services are subject to medical necessity as determined by the plan. Please note that all out-of-network services are subject to Reasonable and Customary (R&C) limitations. The HDHP has no lifetime maximum.

	HDHP	
	IN-NETWORK	OUT-OF-NETWORK
CALENDAR YEAR DEDUCTIBLE		
INDIVIDUAL	$3,200	$5,250
FAMILY	$6,400	$10,500
COINSURANCE (YOU PAY)	0%*	40%*
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (MAXIMUM INCLUDES DEDUCTIBLE)		
INDIVIDUAL	$3,200	$6,000
FAMILY	$6,400	$12,000
COPAYS/COINSURANCE		
PREVENTIVE CARE (Routine Physicals, Well Baby Care, Vision & Hearing Exams)	100% covered	40%*
PRIMARY CARE	0%*	40%*
SPECIALIST SERVICES	0%*	40%*
VIRTUAL VISIT	0%*	40%*
IN/OUTPATIENT HOSPITAL	0%*	40%*
MENTAL HEALTH - INPATIENT	0%*	40%*
MENTAL HEALTH - OUTPATIENT	0%*	40%*
INPATIENT SUBSTANCE ABUSE	0%*	40%*
OUTPATIENT SUBSTANCE ABUSE	0%*	40%*
URGENT CARE	0%*	40%*
EMERGENCY CARE (Facility Charges and Ambulance Charges)	0%*	
EXTENDED CARE (Home Health Care, Skilled Nursing Facility, Hospice Care)	0%* (See HR for maximums)	40%* (See HR for maximums)

*After deductible

The individual deductible amount must be met by each member enrolled under your medical coverage. If you have several covered dependents, all charges used to apply toward a "per individual" deductible amount will also be applied toward the "per family" deductible amount. When the family deductible amount is reached, no further individual deductibles will have to be met for the remainder of that plan year. No member may contribute more than the individual deductible amount to the "per family" deductible amount. The same typically applies for the out-of-pocket maximum.

Healthcare Cost Transparency

There are so many different providers and varying costs for healthcare services — how do you choose? Online services called healthcare cost transparency tools can help. These tools allow you to compare costs for services, from prescriptions to major surgeries, to make your choices simpler. Visit www.bcbstx.com to learn more.

Out-of-Pocket Costs

These are the types of payments you're responsible for:

Copay

The fixed amount you pay for healthcare services at the time you receive them.

Deductible

The amount you must pay for covered services before your insurance begins paying its portion/coinsurance.

Out-of-Pocket Maximum

The most you will pay during the plan year before your insurance begins to pay 100% of the allowed amount.

Coinsurance

Your percentage of the cost of a covered service. If your office visit is $100 and your coinsurance is 20% (and you've met your deductible but not your out-of-pocket maximum), your payment would be $20.

How to Pick a Plan

What plan is right for you? Consider any medical needs you foresee for the upcoming plan year, your overall health, and any medications you currently take.

How does the PPO (Preferred Provider Organization) plan work?

- You'll pay more in premiums, but perhaps less at the time of service.
- You can choose from a network of providers who offer a fixed copay for services.
- You can also use a Flexible Spending Account (FSA) in conjunction, which helps you save for unexpected medical costs and provides tax advantages.
- If you expect to need more medical care this year or you have a chronic illness, the PPO may be the right choice for you to ensure your healthcare needs are covered.

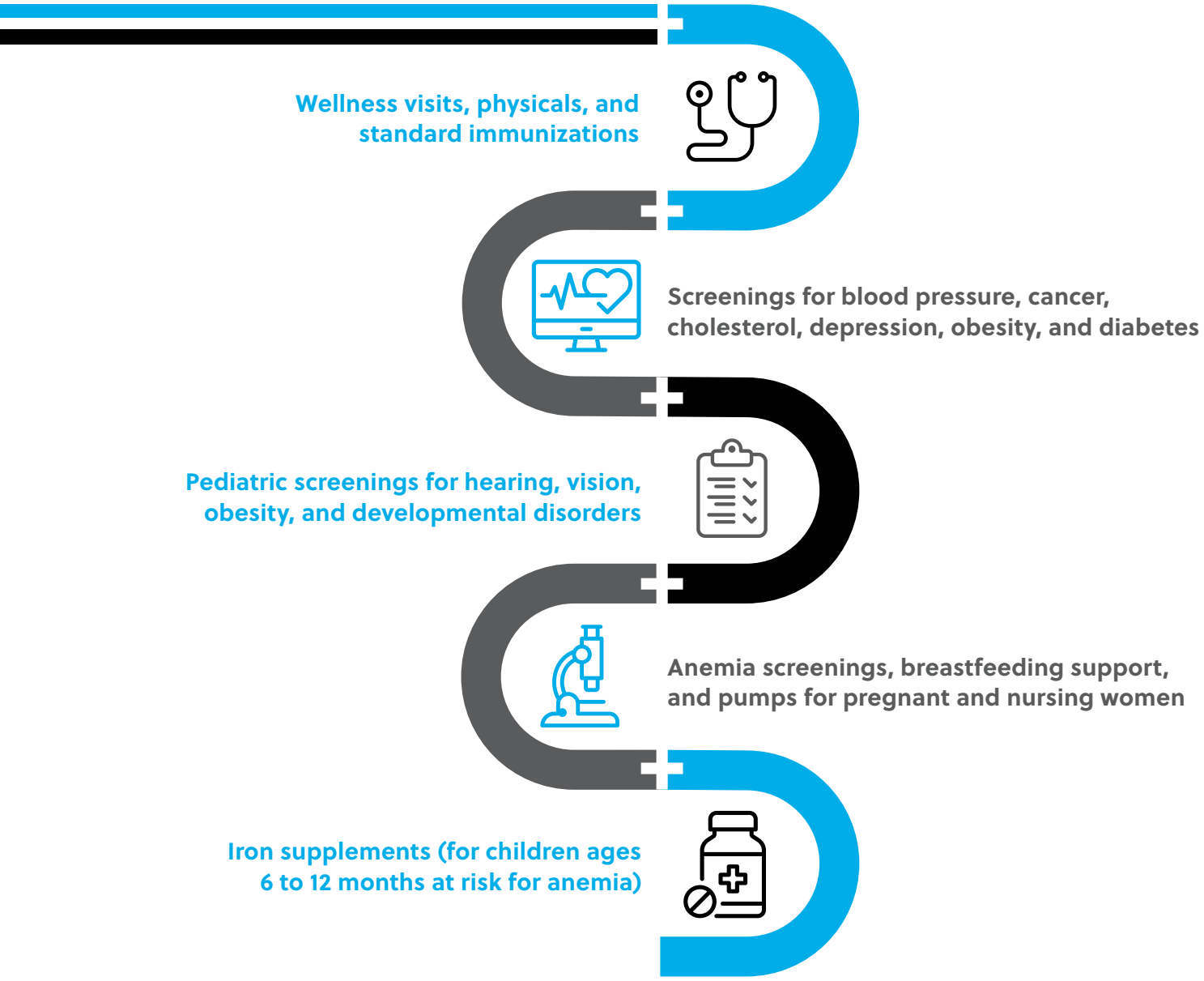
How does the HDHP (High Deductible Health Plan) work?

- You'll pay less in premiums. (Think less money from your paycheck.)
- You'll pay for the full cost of non-preventive medical services until you reach your deductible.
- You can also use a Health Savings Account (HSA) in conjunction, which helps you save for unexpected medical costs and provides tax advantages.
- If you expect to mostly use preventive care (which is covered), this plan could be for you.

Preventive Care

Routine checkups and screenings are considered preventive, so they're often paid at 100% by your insurance.

Keep up to date with your primary care physician to stay on top of your overall health. Under the U.S. Patient Protection and Affordable Care Act (PPACA), some common covered services include:



Don't miss out on these covered services. But remember that diagnostic care to identify health risks is covered according to plan benefits, even if done during a preventive care visit. So, if your doctor finds a new condition or potential risk during your appointment, the services may be billed as diagnostic medicine and result in some out-of-pocket costs. Read over your benefit summary to see what specific preventive services are provided to you.

What about the COVID-19 vaccine?

The COVID-19 vaccine itself is considered preventive. For the vast majority of individuals who have insurance through an employer, the vaccine will be at no cost.


@thebakedbear
SO GOOD
HEART
COOKIES & ICE CREAM
CUSTOM
BAKING MY HEART
LIFE IS SHORT. EAT


ICE CREAM
MANGO
STRAWBERRY
COCONUT

Where to Go for Care

You're feeling sick, but your primary care physician is booked through the end of the month. You have a question about the side effects of a new prescription, but the pharmacy is closed. Instead of rushing to the emergency room or relying on questionable information from the internet, consider all of your site-of-care options.

Virtual Visits

When to Use

You need care for minor illnesses and ailments but would prefer not to leave home. These services are available by phone and online (via webcam).

Types of Care*

- Cold & flu symptoms
- Allergies
- Bronchitis
- Urinary tract infection
- Sinus problems

Costs and Time Considerations**

- Usually a first-time consultation fee and a flat fee or copay for any visit thereafter
- Usually immediate access to care
- Prescriptions through telemedicine or virtual visits not allowed in all states

Primary Care Center

When to Use

You need routine care or treatment for a current health issue. Your primary doctor knows you and your health history, can access your medical records, provide routine care, and manage your medications.

Types of Care*

- Routine checkups
- Immunizations
- Preventive services
- Manage your general health

Costs and Time Considerations**

- Often requires a copay and/or coinsurance
- Normally requires an appointment
- Usually little wait time with scheduled appointment

Urgent Care Center

When to Use

You need care quickly, but it is not a true emergency. Urgent care centers offer treatment for non-life-threatening injuries or illnesses.

Types of Care*

- Strains, sprains
- Minor broken bones (e.g., finger)
- Minor infections
- Minor burns
- X-rays

Costs and Time Considerations**

- Often requires a copay and/or coinsurance usually higher than an office visit
- Walk-in patients welcome, but waiting periods may be longer (urgency decides order)

Do Your Homework

What may seem like an urgent care center could actually be a standalone ER. These facilities come with a higher price tag, so ask for clarification if the word "emergency" appears in the company name.

Emergency Room

When to Use

You need immediate treatment for a serious life-threatening condition. If a situation seems life threatening, call 911 or your local emergency number right away.

Types of Care*

- Heavy bleeding
- Chest pain
- Major burns
- Spinal injuries
- Severe head injury
- Broken bones

Costs and Time Considerations**

- Often requires a much higher copay and/or coinsurance
- Open 24/7, but waiting periods may be longer because patients with life-threatening emergencies will be treated first
- Ambulance charges, if applicable, will be separate and may not be in-network

*This is a sample list of services and may not be all inclusive.

**Costs and time information represent averages only and are not tied to a specific condition or treatment.

Virtual Medicine

When you're under the weather, there's no place like home. And when you're constantly on the go, scheduling a doctor's appointment can easily move down your priority list. Virtual medicine is a convenient and easy way to connect with a doctor on your time.

BCBS offers on-demand access to board-certified doctors through online video, telephone, or secure email. General health issues can be addressed at home for a copay of $20 per consultation on the PPO plan and 100% after deductible on the HDHP plan. Virtual medicine is useful for after-hours non-emergency care, when your primary care doctor is unavailable, if you need prescriptions or refills or if you're traveling. Virtual visits aren't good for conditions requiring exams or tests, complex or chronic problems, or emergencies like sprains or broken bones.

BCBS doctors can share information with your primary care physician with your consent. Please note that some states do not allow physicians to prescribe medications via telemedicine. For more information, visit www.bcbstx.com.

BCBS doctors can treat many medical conditions, including:

- Cold & flu
- Allergies
- Bronchitis
- Bladder infection/ urinary tract infection
- Respiratory infection
- Pink eye
- Sore throat
- Stomachache
- Sinus problems

Access Virtual Visits

Visit www.bcbstx.com to request a virtual visit. After you register and request an appointment, you'll pay your portion of the service costs and enter a virtual waiting room. During your visit, you can talk to a doctor about your health concerns, symptoms, and treatment options.

Activate your account - pick the way that is easiest for you:

Call MDLIVE at 888-680-8646

Go to MDLIVE.com/BCBSTX

Text BCBSTX to 635-483

Download the MDLIVE app

Note

A virtual visit or Facetime directly with your primary care physician (vs. MDLIVE) might also be an option — and typically costs the same as an office visit.

Pharmacy Benefits

Prescription Drug Coverage for Medical Plans

Our Prescription Drug Program is coordinated through BCBSTX. That means you will only have one ID card for both medical care and prescriptions. Information on your benefits coverage and a list of network pharmacies is available online at www.bcbstx.com or by calling the Customer Care number on your ID Card. Your cost is determined by the tier assigned to the prescription drug product. Products are assigned as Generic, Preferred, or Non-Preferred.

Home Delivery Prescription Program

Set up your Express Scripts® Pharmacy digital account using your member ID by going to esrx.com/BCBSTX or by calling 833-715-0942. Once registered, you can send your first order and receive the benefits under the MAIL ORDER RX section of the table below.

	PPO		HDHP	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
RETAIL RX (30-DAY SUPPLY)				
GENERIC	$15 copay	40% of cost after copay	You pay full cost until deductible is met, then plan pays 100% of cost*	40%*
PREFERRED	$30 copay	40% of cost after copay		
NON-PREFERRED	$50 copay	40% of cost after copay		
SPECIALTY	$15/$30/$50 copay	40% of cost after copay		
MAIL ORDER RX (90-DAY SUPPLY)				
GENERIC	$30 copay	No Out-of-Network	You pay full cost until deductible is met, then plan pays 100% of cost*	No Out-of-Network
PREFERRED	$60 copay	No Out-of-Network		No Out-of-Network
NON-PREFERRED	$100 copay	No Out-of-Network		No Out-of-Network

*After deductible

Generic Drugs

Want to save money on meds? Generic drugs are versions of brand-name drugs with the exact same dosage, intended use, side effects, route of administration, risks, safety, and strength. Because they are the same medicine, generic drugs are just as effective as the brand names, and they undergo the same rigid FDA standards. **But generic versions cost 80% to 85% less on average than the brand-name equivalent.** To find out if there is a generic equivalent for your brand-name drug, visit www.fda.gov.

NOTE: Apps and prescription discount programs such as GoodRx, Amazon Prime RX Savings, and Optum Perks let you compare prices of prescription drugs and find possible discounts.

How do they work? These discounts can't be combined with your benefit plan's coverage, so make sure to check the price against the cost of using your insurance's prescription drug benefit. Something else to consider: If you choose to use a discount card and are therefore not tapping into your insurance's prescription drug benefit, the cash amount you pay for the prescription will not count toward your deductible or out-of-pocket maximum under the benefit plan.

GoodRX is a web- and app-based platform that allows you to search for prescription drug coupons and compare pharmacy prices. The company claims a savings of up to 80%. **Optum Perks** also provides coupons for medications and a searchable database for drug cost comparison at participating pharmacies near you. The Optum Perks member card, which can be used at more than 64,000 pharmacies, is free to use and requires no personal data. Another discount option is the **Amazon Prime RX Savings** discount card, which is included with an Amazon Prime membership and is administered by InsideRX. It provides discounts of up to 80% for generics and up to 40% for brand-name medication at participating pharmacies.

Health Savings Account

Want funds handy to help cover out-of-pocket healthcare expenses? A Health Savings Account (HSA) is a personal healthcare bank account used to pay for qualified medical expenses. HSA contributions and withdrawals for qualified healthcare expenses are tax free. You must be enrolled in a HDHP to participate.

Your HSA can be used for qualified expenses for you, your spouse, and/or tax dependent(s), even if they're not covered by your plan. If you are not currently enrolled in a HDHP but you have unused HSA funds from a previous account, those funds can still be used for qualified expenses.

Unlike a Flexible Spending Account (FSA), your unused account balance can be carried over from year to year. And, the account belongs to you, so even if you leave the organization, you can take it with you. HSA Bank will issue you a debit card with direct access to your account balance. Use your debit card to pay for qualified medical expenses — no need to submit receipts for reimbursement. Like a regular debit card, you must have a balance in your HSA account to use the card. You may also write a check from your HSA, in which case you must order checks when you enroll in the HSA.

Eligible expenses include doctors' visits, eye exams, prescription expenses, laser eye surgery, menstrual products, PPE, over-the-counter medications, and more. Visit IRS Publication 502 on www.irs.gov for a complete list.

Eligibility

You are eligible to contribute to an HSA if:

- You are enrolled in an HSA-eligible High Deductible Health Plan.
- You are not covered by your spouse's non-HDHP.
- Your spouse does not have a Healthcare Flexible Spending Account or Health Reimbursement Account.
- You are not eligible to be claimed as a dependent on someone else's tax return.
- You are not enrolled in Medicare or TRICARE.
- You have not received Department of Veterans Affairs medical benefits in the past 90 days for non-service-related care. (Service-related care will not be taken into consideration.)

Tax-free Interest

Employer Contributions
(pre-tax)

Voluntary Contributions

HSA

Tax-free Payments
(for qualified medical expenses)

Note

Not sure how much to contribute? Think about how much you may need in order to cover any anticipated or emergency medical services this year. Consider contributing the amount of your plan's in-network deductible so you know you're covered.

You Own Your HSA

Your HSA is a personal bank account that you own and administer. You decide how much you contribute, when to use the money for medical services and when to reimburse yourself. You can save and roll over HSA funds to the next year if you don't spend them all in the calendar year. You can even let funds accumulate year over year to use for eligible expenses in retirement. HSA funds are also portable if you change plans or jobs. There are no vesting requirements or forfeiture provisions.

How to Enroll

To enroll in Town of Addison's HSA, you must elect the HDHP with Town of Addison. Submit all HSA enrollment materials and choose the amount to contribute on a pre-tax basis. Town of Addison will establish an HSA account in your name and send in your contribution once bank account information has been provided and verified.

HSAs and Taxes

HSA contributions are made through payroll deduction on a pre-tax basis when you open an account with HSA Bank. The money in your HSA (including interest and investment earnings) grows tax free. When the funds are used for qualified medical expenses, they are spent tax free.

Per IRS regulations, if HSA funds are used for purposes other than qualified medical expenses and you are younger than age 65, you must pay federal income tax on the amount withdrawn, plus a 20% penalty tax.

HSA Funding Limits

The IRS places an annual limit on the maximum amount that can be contributed to HSAs. For 2024, contributions (which include any employer contribution) are limited to the following:

HSA FUNDING LIMITS	
EMPLOYEE	$4,150
FAMILY	$8,300
CATCH-UP CONTRIBUTION (AGES 55+)	$1,000

Town of Addison provides an HSA employer contribution if you elect to enroll in the High Deductible Health Plan with an HSA account. Half of the below amount will be contributed to your HSA when you enroll, and the remaining balance will be contributed in 6 months if you have completed the Health Risk Assessment.

TOWN OF ADDISON EMPLOYER HSA CONTRIBUTION	
EMPLOYEE	$500
EMPLOYEE & SPOUSE	$700
EMPLOYEE & CHILD(REN)	$600
EMPLOYEE & FAMILY	$850

HSA contributions over the IRS annual contribution limits ($4,150 for individual coverage and $8,300 for family coverage for 2024) are not tax deductible and are generally subject to a 6% excise tax.

NOTE: If you elect to participate in the HDHP with the Health Savings Account, your FSA balance must be zero in order to open the HSA. You may not participate in the health FSA and the HDHP HSA.

If you've contributed too much to your HSA this year, you have two options:

- Remove the excess contributions and the net income attributable to the excess contribution before you file your federal income tax return (including extensions). You'll pay income taxes on the excess removed.
- Leave the excess contributions in your HSA and pay 6% excise tax on them. Next year consider contributing less than the annual limit to your HSA.

The Town of Addison HSA is established with HSA Bank. You are also able to roll over funds from another HSA. For more enrollment information, contact Human Resources or visit www.hsabank.com.

Flexible Spending Accounts

Take control of your spending! A Flexible Spending Account (FSA) is a special tax-free account you put money into to pay for certain out-of-pocket expenses. The FSA's are administered by TaxSaver Plan. If you enroll, you choose an annual amount you want to contribute. Your contributions are taken from each paycheck throughout the year and deposited in your account. Since this money is taken out of your check before you pay taxes, you pay less taxes. After you pay an eligible expense, you submit a claim form and attach your receipts and submit the documents to TaxSaver. Once approved, you are reimbursed with the pre-tax dollars from your account.

There are two types of FSAs: the Health Care Account and the Dependent Care Account. You can choose to participate in only one of the accounts, both accounts or neither one.

The elections you make to the Health Care and Dependent Care FSA's will be for the plan year beginning on January 1 and remain in effect until December 31, 2024. You cannot change or stop your deductions during the year unless you experience a qualified life event.

Healthcare Flexible Spending Account

You can contribute up to $3,050 annually for qualified medical expenses (deductibles, copays, coinsurance, menstrual products, PPE, over-the-counter medications, etc.) with pre-tax dollars, which reduces your taxable income and increases your take-home pay. You can even pay for eligible expenses with an FSA debit card at the same time you receive them — no waiting for reimbursement.

Dependent Care Flexible Spending Account

In addition to the Healthcare FSA, you may opt to participate in the Dependent Care FSA — even if you don't elect any other benefits. Set aside pre-tax funds into a Dependent Care FSA for expenses associated with caring for elderly or child dependents. Unlike the Healthcare FSA, reimbursement from your Dependent Care FSA is limited to the total amount that is currently deposited in your account.

- With the Dependent Care FSA, you can set aside up to $5,000 to pay for child or elder care expenses on a pre-tax basis.
- Eligible dependents include children under 13 and a spouse or other individual who is physically or mentally incapable of self-care and has the same principal place of residence as the employee for more than half the year.
- Expenses are reimbursable if the provider is not your dependent.
- You must provide the tax identification number or Social Security number of the party providing care to be reimbursed.

This account covers dependent day care expenses that are necessary for you and your spouse to work or attend school full time. When you file a Dependent Care Account claim, you are only reimbursed up to the amount in your account at the time you file your claim. For instance, if you have incurred $300 in expenses, but you only have $200 in your account, you will be reimbursed only $200. Additional reimbursement will be made as you make semi-monthly contributions to your account though payroll deductions. Eligible expenses include:

- In-home babysitting services (not provided by a dependent)
- Care of a preschool child by a licensed nursery or day care provider
- Before- and after-school care
- Day camp
- In-house dependent day care

Due to federal regulations, expenses for your domestic partner and your domestic partner's children may not be reimbursed under the FSA programs. Check with your tax advisor to determine if any exceptions apply.

Using the Account

Submit a claim form along with the required documentation. Contact TaxSaver with reimbursement questions. If you need to submit a receipt, TaxSaver will notify you. Always save receipts for your records.

General Rules

The IRS has the following rules for Healthcare and Dependent Care FSAs:

- Expenses must occur during the 2024 plan year.
- Funds cannot be transferred between FSAs.
- You cannot participate in a Dependent Care FSA and claim a dependent care tax deduction at the same time.
- **You must "use it or lose it" — any unused funds will be forfeited.**
- You cannot change your FSA election in the middle of the plan year without a qualifying life event.
- Terminated employees have ninety (90) days following termination to submit FSA claims for reimbursement.
- Those considered highly compensated employees (family gross earnings were $135,000 or more last year) may have different FSA contribution limits. Visit www.irs.gov for more info.

How Long Do I Have to Use the Funds in my FSA?

- Although the plan year runs from January 1 to December 31, 2024, both the Health Care and Dependent Care FSA have an additional 2½-month grace period to incur expenses after the plan year ends (December 31, 2024).
- If an expense occurs between December 31, 2024 and March 15, 2025, AND is submitted for reimbursement on or before March 31, 2025, any remaining balance in the previous plan year that ended December 31, 2024, will be paid out from the claim, even though the service was provided in the NEW plan year.
- The grace period applies to both the Dependent Care and Healthcare FSAs.

Receipts Needed (always complete a claim form):

All receipts should be itemized statements from the provider. Please do not submit receipts that show only the payment amount. Dates and types of services rendered should be listed on the receipt, along with the name of the provider. Receipts for prescriptions and over-the-counter expenses should include the name of the drug or over-the-counter item purchased, along with the date and amount of the charge. For dependent care, please include the dates of services that you are paying for and the amount charged.

FSA vs HSA

Flexible Spending Accounts		Health Savings Accounts
Your employer owns your FSA. If you leave your employer, you lose access to the account unless you have a COBRA right.	OWNERSHIP	You own your HSA. It is a savings account in your name, and you always have access to the funds, even if you change jobs.
You can elect a Healthcare FSA even if you waive other coverage. You cannot make changes to your contribution during the Plan Year without a Qualifying Life Event. You cannot be enrolled in both a Healthcare FSA and an HSA.	ELIGIBILITY & ENROLLMENT	You must be enrolled in a Qualified HDHP to contribute money to your HSA. You cannot be covered by a spouse's non-High Deductible plan or a spouse's FSA or enrolled in Medicare or TRICARE. You can change your contribution at any time during the Plan Year.
FSA contributions are tax free via payroll deduction. Funds are spent tax free when used for qualified expenses.	TAXATION	HSA contributions are tax free; the account grows tax free; and funds are spent tax free on qualified expenses.
Both you and your employer can contribute up to $3,050 combined in 2024 (up to $5,000 for dependent care) to an FSA.	CONTRIBUTIONS	Both you and your employer can contribute up to $4,150 combined in 2024 (up to $8,300 for families). Ages 55+ can make an annual $1,000 "catch-up" HSA contribution.
Some plans include an FSA debit card to pay for eligible expenses. If not, you pay up front and submit receipts for reimbursement.	PAYMENT	Many HSAs include a debit card to pay for qualified expenses directly. Alternatively, you can save funds for future expenses or retirement.
Any unclaimed funds at the end of the year are forfeited. Exceptions might include an additional 2.5-month grace period for expenses to be incurred and reimbursed, or an allowed rollover amount.	ROLLOVER OR GRACE PERIOD	HSA funds roll over from year to year. The account is portable and may be used for future qualified expenses — even in retirement years.
Physician services, hospital services, prescriptions, menstrual products, PPE, over-the-counter medications, dental care, and vision care. A full list is available at www.irs.gov.	QUALIFIED EXPENSES	Physician services, hospital services, prescriptions, menstrual products, PPE, over-the-counter medications, dental care, vision care, Medicare Part D plans, COBRA premiums, and long-term care premiums. A full list is available at www.irs.gov.
Dependent Care FSA (pre-tax dollars can be used for elder or child dependent care) and Limited Use FSA (used to pay for eligible dental and vision expenses).	OTHER TYPES	N/A


CORPORATE FIELD DAY 2023
SMOOTH
EVENTS

Dental Benefits

Like brushing and flossing, visiting your dentist is an essential part of your oral health. Town of Addison offers affordable plan options from Delta Dental for routine care and beyond.

Stay In-Network

You can visit any dentist; however, if you visit a Delta Dental network dentist a discount will be applied to your dental services. You do not have to select a primary dentist, and you do not have to receive referrals for specialty care.

To see the most current list of Dental PPO network providers, go online to the Delta Dental dentist finder at www.deltadentalins.com.

Dental Premiums

Dental premium contributions are deducted from your paycheck on a pre-tax basis. Your tier of coverage determines your bi-weekly premium.

Dental Plan Summary

This chart summarizes the dental coverage provided by Delta Dental for 2024. You don't need a Delta Dental ID card when you visit the dentist. Just provide your name, birth date and enrollee ID or social security number. If your family members are covered under your plan, they will need your information.

	DENTAL PLAN					
BI-WEEKLY CONTRIBUTIONS						
	EMPLOYEE COSTS (FULL TIME)	**ADDISON COSTS (FULL TIME)**	**EMPLOYEE COSTS (PART TIME .7)**	**ADDISON COSTS (PART TIME .7)**	**EMPLOYEE COSTS (PART TIME .5)**	**ADDISON COSTS (PART TIME .5)**
EMPLOYEE ONLY	$0.00	$15.94	$4.78	$11.16	$7.97	$7.97
EMPLOYEE + SPOUSE	$7.50	$23.45	$14.54	$16.41	$19.23	$11.72
EMPLOYEE + CHILD(REN)	$9.13	$25.07	$16.65	$17.55	$21.66	$12.54
EMPLOYEE + FAMILY	$19.63	$35.58	$30.31	$24.90	$37.42	$17.79
	IN-NETWORK & OUT-OF-NETWORK					
ANNUAL DEDUCTIBLE: WAIVED FOR DIAGNOSTIC & PREVENTIVE (D&P) AND ORTHODONTICS						
INDIVIDUAL	$50					
FAMILY	$150					
ANNUAL MAXIMUM: D&P COUNTS TOWARD MAXIMUM						
PER PERSON	$1,500					
COVERED SERVICES						
DIAGNOSTIC & PREVENTIVE SERVICES (D&P) Exams, Cleanings and X-rays	Plan pays 100%					
BASIC SERVICES Fillings, Simple Tooth Extractions, Sealants, Endodontics (root canals), Periodontics (gum treatment), Oral Surgery	Plan pays 80%*					
MAJOR SERVICES Prosthodontics (bridges and dentures), Crowns, Inlays/Onlays and Cast Restorations	Plan pays 50%*					
ORTHODONTICS Dependent Child(ren) Only to Age 25	Plan pays 50% after $50 lifetime deductible					
ORTHODONTIC LIFETIME MAXIMUM	$1,500 lifetime maximum per person					

*After deductible

Vision Benefits

Getting your eyes checked regularly is important even if you don't wear glasses or contacts. We provide quality vision care for you and your family through BCBSTX.

Vision Premiums

Vision premium contributions are deducted from your paycheck on a pre-tax basis. Your tier of coverage determines your bi-weekly premium.

How to Find an Eye Doctor:

- **Use the Enhanced Provider Search on eyemedvisioncare.com/bcbstxvis**
- **Download and use the EyeMed Members App (available in the App Store or Google Play)**
- **Check the listing of the closest eye doctors from your Welcome Kit**

Vision Plan Summary

This chart summarizes the vision coverage provided by BCBSTX for 2024.

VISION PREMIUMS (FULL-TIME & PART-TIME)

BI-WEEKLY CONTRIBUTIONS			
EMPLOYEE ONLY	$3.60		
EMPLOYEE + SPOUSE	$6.84		
EMPLOYEE + CHILD(REN)	$7.20		
EMPLOYEE + FAMILY	$10.59		
	IN-NETWORK	**OUT-OF-NETWORK REIMBURSEMENT**	**FREQUENCY**
EXAM (WITH DILATION AS NECESSARY)			
COPAY	$10 Copay	Up to $30	
LENSES*			
SINGLE VISION	$10 Copay	Up to $25	Once every 12 months
BIFOCAL	$10 Copay	Up to $40	
TRIFOCAL	$10 Copay	Up to $55	
LENTICULAR	$10 Copay	Up to $55	
STANDARD PROGRESSIVE LENS	$75 Copay	Up to $40	
PREMIUM PROGRESSIVE LENS	See Full BCBS Summary for Progressive Price List	Up to $40	
CONTACTS (IN LIEU OF LENSES AND FRAMES)			
FITTING AND EVALUATION**	Up to $40 for Standard; 10% off retail price for Premium	N/A	Once every 12 months
ELECTIVE	$0 Copay; $130 allowance plus balance over $130	Up to $104	
MEDICALLY NECESSARY	$0 Copay, Paid in Full	Up to $210	
FRAMES (ANY AVAILABLE FRAME AT PROVIDER LOCATION)			
COPAY	$0 Copay	Up to $65	Once every 24 months
ALLOWANCE	$130, 20% off balance over $130		
OTHER SERVICES			
LASER VISION CORRECTION	15% off Retail Price or 5% off Promotional Price		
ADDITIONAL PAIRS BENEFIT	40% off purchase of complete pair of eyeglasses and a 15% off conventional contact lenses once the funded benefit has been used		
AMPLIFON HEARING DISCOUNT	40% off hearing exams and low price guarantee on discounted hearing aids		
ADDITIONAL DISCOUNTS	20% off non-covered items with limitations		

*See full BCBSTX summary for Lens Options including detail on tint, polycarbonate, UV and anti-reflective coating, and transition lenses.
**Fitting and Evaluation fee applied to contact lens allowance.

Survivor Benefits

It's hard to think about, but it's important to have a plan in place to provide for your family if something were to happen to you. Survivor benefits provide financial protection in the event of an unexpected event administered by The Hartford Life and Accident Insurance Company.

Basic Life and Accidental Death & Dismemberment Insurance

Town of Addison provides employees with Basic Life and Accidental Death and Dismemberment (AD&D) insurance as part of your basic coverage through The Hartford Life and Accident Insurance Company, which guarantees that your spouse or other designated survivor(s) continue to receive benefits in the event of your death. AD&D insurance provides a high-benefit lump sum if you were to die as a result of a covered accident. It also pays partial benefits if you lose your vision, hearing, speech or limb in a covered accident. Benefits are paid in addition to any life insurance you may have.

Your Basic Life and AD&D insurance benefit is 2 X Salary, up to $200,000. If you are a full-time employee, you automatically receive Life and AD&D insurance at no cost to you, even if you waive other coverage.

Naming a Beneficiary

You MUST designate a beneficiary for your life and AD&D insurance when you become eligible for coverage. You may change your beneficiary at any time.

Your beneficiary is the person you designate to receive your Life insurance benefits in the event of your death. This includes any benefits payable under Basic Life. You receive the benefit payment for a dependent's death. If you do not name a beneficiary, or if your beneficiary dies before you, benefits will be paid to your estate.

Name a primary and contingent beneficiary to make your intentions clear. Indicate their full name, address, Social Security number, relationship, date of birth, and distribution percentage. Please note that in most states, benefit payments cannot be made to a minor. If you elect to designate a minor as beneficiary, all proceeds may be held under the beneficiary's name and will earn interest until the minor reaches age 18. Contact Human Resources or your own legal counsel with any questions.

Benefit Reductions

At the age of 65, 70, and 75, employees will receive a 35% benefit reduction. At the age of 80, 85, 90, and 95, employees will receive a 25% benefit reduction. All coverage cancels at retirement.

Living Benefits Option

If you are diagnosed as terminally ill with a 12 month life expectancy, you may be eligible to receive payment of a portion of your life insurance. The remaining amount of your life insurance would be paid to your beneficiary when you die.

Supplemental Life and AD&D Insurance

Supplemental dependent life insurance coverage for your spouse or domestic partner and/or children is available if you elect supplemental life insurance for yourself. You may elect to cover your spouse or domestic partner and children, your spouse or domestic partner only, or your children only. This is an optional, employee-paid benefit. All supplemental life insurance premiums are paid for through payroll deductions on an after-tax basis.

SUPPLEMENTAL EMPLOYEE LIFE	
COVERAGE AMOUNT	3 X Annual earnings in 1 X annual earnings increments up to a maximum of $400,000
WHO PAYS	Employee
MAXIMUM BENEFIT	$400,000
EVIDENCE OF INSURABILITY (EOI) REQUIRED*	Yes: when electing any amount over the lesser of Guaranteed Issue Amount of $200,000 or 3 X annual earnings
SUPPLEMENTAL SPOUSE LIFE	
COVERAGE AMOUNT	$10,000 increments
WHO PAYS	Employee
MAXIMUM BENEFIT	$50,000 (cannot exceed 50% of the amount of combined employee basic and supplemental life insurance coverage). You may not elect coverage for your spouse if they are in active full-time military service or is already covered as an employee under the policy.
EVIDENCE OF INSURABILITY (EOI) REQUIRED*	Yes: when electing any amount over the Guaranteed Issue Amount of $20,000
SUPPLEMENTAL CHILD LIFE	
COVERAGE AMOUNT	$5,000 or $10,000 (ages 15 days to 25 years)
WHO PAYS	Employee
MAXIMUM BENEFIT	$5,000 or $10,000
EVIDENCE OF INSURABILITY (EOI) REQUIRED	No

*Guarantee issue only applies upon initial eligibility. If you do not enroll within 30 days of your first day of eligibility, you will be considered a late entrant. Late entrants will need to show evidence of insurability for all elections, regardless.

Dependent Eligibility – Supplemental Life

- Your legal spouse or domestic partner
- Your natural child, stepchild, adopted child or any other child who is related to you by blood or marriage who is unmarried and:
  - 1) At least 15 days old but not yet age 25; or
  - 2) Age 25 or older and physically or mentally disabled and living under your supervision. Your natural or adopted grandchildren will qualify as a dependent provided the child is at least 15 days old but not yet age 25 and under your supervision and you can claim them as a dependent.
- Physically or mentally disabled children of any age who are incapable of self-support. Proof of disability may be requested, and disability must have occurred prior to age 25.

Long Term Disability

You and your loved ones depend on your regular income. That's why Town of Addison pays for Long Term Disability (LTD) coverage through UNUM to protect you financially in the event you cannot work as a result of a debilitating injury. Active full-time employees or part-time benefited employees working a minimum of 20 hours per week are automatically enrolled in LTD coverage so that a portion of your income is protected until you can return to work or you reach retirement age.

Long Term Disability (LTD) Insurance

Long Term Disability (LTD) benefits are available at no additional cost to you. This insurance replaces 60% of your income if you become partially or totally disabled for an extended time. Certain exclusions, along with pre-existing condition limitations, may apply. See your plan documents or Human Resources for details.

MONTHLY MAXIMUM BENEFIT	$5,000
ELIMINATION PERIOD (benefits begin after)	180 days
ELIGIBLE DATE	Date of Hire
MAXIMUM BENEFIT PERIOD	Payments will last for as long as you are disabled or until you reach your Social Security Normal Retirement Age, whichever is sooner.

LTD	
MAXIMUM PERIOD OF PAYMENT	
AGE AT DISABILITY	LTD
Less than age 60	To age 65, but not less than 5 years
Age 60	60 months
Age 61	48 months
Age 62	42 months
Age 63	36 months
Age 64	30 months
Age 65	24 months
Age 66	21 months
Age 67	18 months
Age 68	15 months
Age 69 and over	12 months

Claim Information

When do you notify Human Resources of your claim?

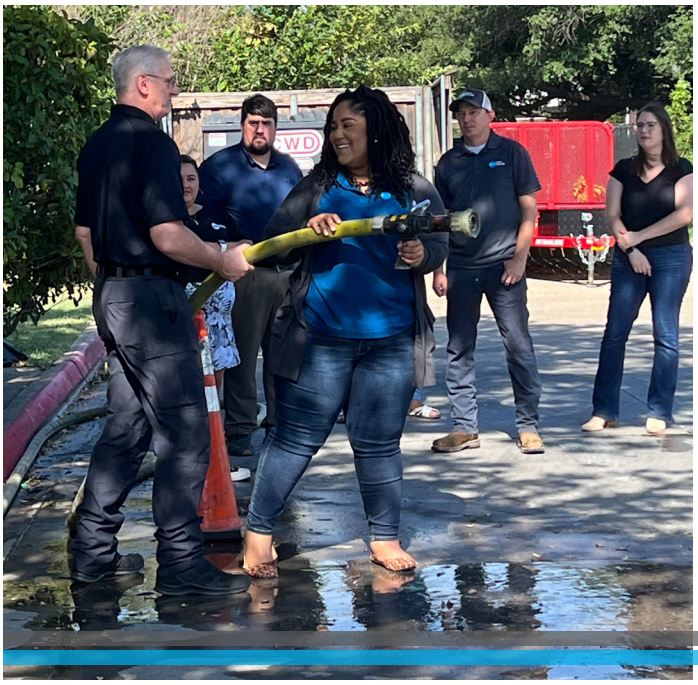
You must notify Human Resources immediately. Written notice of the claim should be sent to UNUM within 30 days after the date your disability begins. However, the claims must be submitted no later than 90 days after your elimination period. The claim form is available with Human Resources.

How do you file a claim?

The employee and Human Resources will fill out their own sections of the claim form and then give it to your attending physician. The physician should fill out his or her section of the form and send it directly to Unum.

To Whom will UNUM make payments?

UNUM will make payments directly to the employee.



Retirement Planning

No matter what point of your career you're in, it's never a bad time to think about your future and save for retirement.

TMRS

The Town of Addison is a member of the Texas Municipal Retirement System (TMRS). All benefited employees will be automatically enrolled in the TMRS pension planning beginning with your first payroll check.

- Employees make a 7% contribution (a required automatic deduction from paycheck) of their gross income, tax deferred.
- Upon retirement, the Town matches your contributions and interest earned at a rate of two to one, the maximum allowable under the plan.
- You are eligible to retire when you are vested and are at least age 60 or if you have 20 years of service credit at any age.
- Retirement benefits are vested after 5 years of employment.
- Additionally, TMRS provides a one-time life insurance benefit of your annual salary.

Call 800-924-8677 or visit www.tmrs.com.

457 Deferred Compensation Plan

In addition to TMRS, the Town offers a 457 Deferred Compensation Plan as an option an easy way for employees to supplement their retirement benefits. The Deferred Compensation plan through MissionSquare offers tax savings and additional funds contributed from the Town and includes a loan feature.

After you have passed your initial 6-month trial period, your contributions are matched by the Town at a 2/3 rate, up to a maximum of 4% of your base salary (subject to current legislative maximum contributions). These matching funds are vested immediately.

Call 800-669-7400 or visit www.missionsq.org.

Employee Assistance Program

Town of Addison wants you to succeed in all aspects of life, so we offer a variety of additional benefits to make your day-to-day easier:

The Employee Assistance Program (EAP) offers support, guidance and resources that can help you resolve personal issues and meet life's challenges. This service is provided at no additional cost to you by your employer, in connection with your Group Long Term Disability coverage from Unum.

We're here for you when you need help. Our Employee Assistance Program (EAP) helps manage your and your family's total health, including mental, emotional, and physical. And there's no cost to you — whether or not you're enrolled in a company-sponsored medical plan.

Through the EAP, you have access to mental health assistance and legal and financial help from professionals. You also have 24-hour access to helpful resources by phone, and the EAP benefit includes three face-to-face visits per issue with a licensed professional. All services provided are confidential and will not be shared with Town of Addison. You may access information, benefits, educational materials, and more by phone at **800-854-1446** or online at **www.unum.com/lifebalance**.

The Program provides referrals to help with:

- Emotional health and wellbeing
  - Includes: substance dependency, marriage or family conflicts, stress, anxiety, depression, grief and loss
- Legal Services
  - Includes: personal/family and elder law, real estate, and identity theft
- Financial advice
  - Includes: debt management solutions, budgeting assistance, and child report assistance
- Eldercare Services
  - Includes: assisted living facilities, nursing homes, independent living options, adult day-care services, geriatric care managers, and services for adults with disabilities
- Childcare services
  - Includes: childcare centers, babysitter tips, family-run child care homes, community resources, nanny agencies, and pre-schools

Additional Key Features

- Medical Bill Saver™ service that can help negotiate out-of-pocket medical and dental expenses over $400.
- 24/7 access to master's level staff clinicians for information, assessment, short-term problem resolution and referrals.
- Up to 3 face-to-face counseling sessions. Sessions are conducted by a network of qualified EAP consultants.
- In lieu of face-to-face sessions, HIPAA-compliant video counseling sessions for those in rural communities, those with transportation concerns, or those that may prefer the use of technology to receive the service.
- Access to a national network of over 60,000 licensed EAP affiliates. All EAP providers have a master's degree or higher with state licensure.
- Travel assistance to help you when you travel to another city or country and can assist with helping you locate hospitals, embassies, or other "unexpected" travel destinations.

Wellness

At the Town of Addison, we are committed to providing wellness opportunities throughout the year to help promote an overall wellbeing and healthy lifestyle. The wellness program consists of various activities. Below is a description of some of the programs offered.

Annual Wellness Fair

The Human Resources Department hosts an annual benefits fair that invites companies from different backgrounds to help employees reach their overall well-being goals.

Annual Flu Shot Clinic

Free flu shots for employees and family members.

Lunch and Learns

Hosted throughout the year on various topics including but not limited to overall nutrition, exercise habits, financial management, stress management, and medical insurance basics.

Glossary

Balance Billing – When you are billed by a provider for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $60, you may be billed by the provider for the remaining $40.

Coinsurance – Your share of the cost of a covered healthcare service, calculated as a percent of the allowed amount for the service, typically after you meet your deductible.

Copay – The fixed amount you pay for healthcare services received, as determined by your insurance plan.

Deductible – The amount you owe for healthcare services before your insurance begins to pay its portion. For example, if your deductible is $1,000, your plan does not pay anything until you've paid $1,000 for covered services. This deductible may not apply to all services, including preventive care.

Explanation of Benefits (EOB) – A statement from your insurance carrier that explains which services were provided, their cost, what portion of the claim was paid by the plan, and what portion is your liability, in addition to how you can appeal the insurer's decision.

Flexible Spending Accounts (FSAs) – A special tax-free account you put money into that you use to pay for certain out-of-pocket healthcare costs. You'll save an amount equal to the taxes you would have paid on the money you set aside. FSAs are "use it or lose it," so funds not used by the end of the plan year will be lost. Some Healthcare FSAs do allow for a grace period or rollover into the next plan year.

- **Healthcare FSA –** A pre-tax benefit account used to pay for eligible medical, dental, and vision care expenses that aren't covered by your insurance plan. All expenses must be qualified as defined in Section 213(d) of the Internal Revenue Code.
- **Dependent Care FSA –** A pre-tax benefit account used to pay for dependent care services. For additional information on eligible expenses, refer to Publication 503 on the IRS website.

Healthcare Cost Transparency – Also known as market transparency or medical transparency. Online cost transparency tools, available through health insurance carriers, allow you to search an extensive national database to compare varying costs for services.

Health Savings Account (HSA) – A personal healthcare bank account funded by your or your employer's tax-free dollars to pay for qualified medical expenses. You must be enrolled in a HDHP to open an HSA. Funds contributed to an HSA roll over from year to year and the account is portable if you change jobs.

High Deductible Health Plan (HDHP) – A plan option that provides choice, flexibility, and control when it comes to healthcare spending. Most preventive care is covered at 100% with in-network providers, and all qualified employee-paid medical expenses count toward your deductible and out-of-pocket maximum.

Network – A group of physicians, hospitals, and healthcare providers that have agreed to provide medical services to a health insurance plan's members at discounted costs.

- **In-Network –** Providers that contract with your insurance company to provide healthcare services at the negotiated carrier discounted rates.
- **Out-of-Network –** Providers that are not contracted with your insurance company. If you choose an out-of-network provider, services will not be covered at the in-network negotiated carrier discounted rates.
- **Non-Participating –** Providers that have declined entering into a contract with your insurance provider. They may not accept any insurance and you could pay for all costs out of pocket.

Open Enrollment – The period set by the employer during which employees and dependents may enroll for coverage.

Out-of-Pocket Maximum – The most you pay during the plan year before your health insurance begins to pay 100% of the allowed amount. This does not include your premium, out-of-network provider charges beyond the Reasonable & Customary, or healthcare your plan doesn't cover. Check with your carrier to confirm what applies to the maximum.

Over-the-Counter (OTC) Medications – Medications available without a prescription.

Prescription Medications – Medications prescribed by a doctor. Cost of these medications is determined by their assigned tier: generic, preferred, non-preferred, or specialty.

- **Generic Drugs –** Drugs approved by the U.S. Food and Drug Administration (FDA) to be chemically identical to corresponding preferred or non-preferred versions. Usually the most cost-effective version of any medication.
- **Preferred Drugs –** Brand-name drugs on your provider's approved list (available online).
- **Non-Preferred Drugs –** Brand-name drugs not on your provider's list of approved drugs. These drugs are typically newer and have higher copayments.
- **Specialty Drugs –** Prescription medications used to treat complex, chronic, and often costly conditions. Because of the high cost, many insurers require that specific criteria be met before a drug is covered.
- **Prior Authorization –** A requirement that your physician obtain approval from your health insurance plan to prescribe a specific medication for you.
- **Step Therapy –** The goal of a Step Therapy Program is to steer employees to less expensive, yet equally effective, medications while keeping member and physician disruption to a minimum. You must typically try a generic or preferred-brand medication before "stepping up" to a non-preferred brand.

Reasonable and Customary Allowance (R&C) – The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The R&C amount is sometimes used to determine the allowed amount. Also known as the UCR (Usual, Customary, and Reasonable) amount.

Summary of Benefits and Coverage (SBC) – Mandated by healthcare reform, you are provided with a summary of your benefits and plan coverage.

Summary Plan Description (SPD) – The document(s) that outline the rights, obligations, and material provisions of the plan(s) to all participants and their beneficiaries.

Required Notices

Important Notice from Town of Addison About Your Prescription Drug Coverage and Medicare under the BCBSTX Plan(s)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Town of Addison and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Town of Addison has determined that the prescription drug coverage offered by the BCBSTX plan(s) is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Town of Addison coverage may not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed herein.

If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Town of Addison and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information about This Notice or Your Current Prescription Drug Coverage…

Contact the person listed at the end of these notices for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Town of Addison changes. You also may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Medicare Part D notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	January 1, 2024
Name of Entity/Sender:	Town of Addison
Contact—Position/Office:	Human Resources
Address:	5300 Belt Line Road Dallas, TX 75254
Phone Number:	972-450-2819

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. For deductibles and coinsurance information applicable to the plan in which you enroll, please refer to the summary plan description. If you would like more information on WHCRA benefits, please contact Human Resources at 972-450-2819.

HIPAA Privacy and Security

The Health Insurance Portability and Accountability Act of 1996 deals with how an employer can enforce eligibility and enrollment for health care benefits, as well as ensuring that protected health information which identifies you is kept private. You have the right to inspect and copy protected health information that is maintained by and for the plan for enrollment, payment, claims and case management. If you feel that protected health information about you is incorrect or incomplete, you may ask your benefits administrator to amend the information. For a full copy of the Notice of Privacy Practices, describing how protected health information about you may be used and disclosed and how you can get access to the information, contact Human Resources at 972-450-2819.

HIPAA Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to later enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage).

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (i.e. legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of coverage under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you must request enrollment within 30 days after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or the CHIP, you may request enrollment under this plan within 60 days of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy towards this plan, you may request enrollment under this plan within 60 days after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact Human Resources at 972-450-2819.

Important Contacts

Medical
Blue Cross Blue Shield of Texas
(BCBSTX)
800-521-2227
www.bcbstx.com
Policy #: 172549

COBRA
Health Care Service Corporation
888-541-7107

Telemedicine
MDLive
888-680-8646
www.MDLive.com/BCBSTX

Dental
Delta Dental
800-521-2651
www.deltadentalins.com
Policy #: 03688

Vision
BCBSTX
844-556-8796
eyemedvisioncare.com/bcbstxvis
Policy #: VF023455

Health Savings Account
HSA Bank
Client Assistance Center
855-731-5220
www.hsabank.com

Flexible Spending Accounts
TaxSaver
800-328-4337
www.taxsaverplan.com

Life and AD&D
The Hartford Life and Accident
Insurance Company
800-523-2233
www.thehartford.com
Policy #: 218702G

Disability
UNUM
800-858-6843
www.unum.com
Policy #: 585335

Retirement
Texas Municipal Retirement Systems
(TMRS)
800-924-8677
www.tmrs.com

457 Deferred Compensation Plan
MISSIONSQUARE
800-669-7400
www.missionsq.org

Employee Assistance Program
UNUM
800-854-1446
www.unum.com/lifebalance

For General Benefits Questions: Contact Town of Addison Human Resources
5300 Belt Line Road
Dallas, TX 75254
972-450-2816